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(*Quoted from the Constitution*)

"To promote the study and dissemination of knowledge of the cause, prevention and control of diseases of the teeth, their supporting structures and adnexa and related subjects; and to foster and promote a better scientific understanding between the fields of dentistry and medicine."

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THE ROLE OF DENTAL MEDICINE IN THE PREVENTION OF SYSTEMIC DISEASE*

ALBERT D. PARETS, M.D., *New York, N. Y.*

It has often been said that the dental consultant is in a strategic position for discovering systemic disease long before a patient is aware of its existence. This statement deserves emphasis in to-day's symposium devoted to the role of dental medicine in prevention of disease generally. In order to make a significant contribution toward preventing systemic disease the dentist must always direct his thinking toward systemic disease and not be content with accidentally discovering signs of general disorders. In one sense the dentist is constantly preventing medical disease by practicing excellent therapeutic dentistry. Administration of adequate quantities of antibiotics before and after tooth extraction in patients with rheumatic heart disease, congenital heart disease and healed subacute bacterial endocarditis is directed toward this end. Proper choice of anesthesia for patients with other cardiac disorders or with pulmonary disease is also aimed at preventing systemic disease, as is the creation of properly fitting dentures. The remarkable developments in periodontia and orthodontia are preventive in nature and are designed to accomplish more than save teeth or make them handsome. However, if dental medicine is to make the greatest possible contribution to preventive medicine, its members must school themselves to look not only in the mouth for systemic disease, but elsewhere. Every patient should be observed as a whole insofar as it is possible for the dentist to do so. In short, the patient must be regarded as something more than a vehicle for teeth — whether natural or artificial. Other body areas which are easily accessible and usually exposed should receive attention, for only in this way, will more systemic diseases be detected by the dentist, investigated by the physician and finally revealed in the population as a whole.

GENERAL INSPECTION OF THE DENTAL PATIENT

How shall the dental physician proceed if he is to help prevent systemic disease? When examining a new patient look at him with medical interest, not only dental interest. Instead of immediately sweeping mirror and explorers into the mouth, attempt to make a general judgment of the patient's physique and appearance. The obese patient or the one who is much too lean is often fertile soil for other disorders. It will not be amiss in these cases to inquire about the patient's weight and whether or not there has been a recent change. All obese patients should be under medical supervision, because obesity is, at the very least, a substrate or a contributing factor toward other illness. Patients who are losing weight or appear malnourished will also be well-advised to seek medical care even though no other complaints are offered.

Learn to inspect the patient carefully. Does something about the shape or color of the face seem abnormal? Are the eyes reasonably clear, are the sclera injected or icteric? Is a stare present; or perhaps slight exophthalmos? If exophthalmos is detected do not hesitate to examine for the presence of an enlarged thyroid gland, feel of the pulse for tachycardia, and of the palms for the warm, moist skin characteristic of Graves' disease. Hand tremor is to be tested for also. These simple procedures of inspection and palpation of areas within reach of every dentist may lead to a strong impression that hyperthyroidism is present. Removal of even a loose tooth from such a patient may precipitate a thyroid crisis,

* Presented at the Mid-Winter Meeting of the American Academy of Dental Medicine, New York, N. Y., December 2, 1951.

an acute medical emergency. Hyperthyroid patients are notoriously subject to dental caries and periodontitis, but it seems more likely that the dentist will suspect thyroid overactivity sooner by the signs mentioned than by examining the teeth. Referral of such a patient to a physician may obviate prolonged illness.

Definitive diagnosis of mild thyroid hyperactivity is made more readily today, now that new tests have been developed. Measurement of radioactive iodine uptake by the thyroid gland and serum protein bound iodine determinations can be used to supplement basal metabolism tests in doubtful cases. Similarly treatment of Graves' disease has become simpler and safer. Many clinics are substituting orally administered radioactive iodine (I_{131}) for surgery and thiouracil compounds. The results are excellent, and it is likely that fewer and fewer thyroidectomies will be done in the near future.

Examination of the facial skin often reveals signs. Aside from obvious common dermatoses note whether there are lesions suspicious of carcinoma especially in elderly patients. Be especially wary of isolated pink pearly lesions and ask about their duration and recent rate of growth. Many oral diagnosticians have been the first to discover early skin carcinoma.

Also to be detected on the face are signs associated with disturbed cholesterol metabolism. Hypercholesterolemia is a relatively common disorder and often reveals itself by stigmata such as xanthelasma and arcus of the cornea which, for a long time, were believed to be of little clinical significance. Xanthelasma occur as tan, yellow or faintly orange plaques most frequently situated on the eyelids near the inner canthi. They may be round, oval or irregular, single or multiple. Arcus appears as a grayish band just within the circular edge of the cornea and may occupy the whole circumference or only a portion of it. If found in patients under fifty years, it should be investigated. While neither xanthelasma nor corneal arcus are necessarily indicative of disease they are not infrequently associated with diabetes mellitus, coronary atherosclerosis and familial hypercholesterolemia. Such diseases may exist without the patient's knowledge; early detection is important. Determination of serum cholesterol and urinalysis are always indicated. A high serum cholesterol necessitates complete medical examination and electrocardiography. Latent coronary artery disease may thus be revealed and permit prophylactic measures to be instituted before myocardial infarction supervenes. Coincidentally, the dentist also spares himself the unpleasant experience that occasionally follows injection of procaine-epinephrine into a patient in whom heart disease was unsuspected.

The new patient's complexion is worth noting. In the presence of moderately severe anemia, pallor will often be apparent, but do not expect it with mild anemia. On the other hand a florid face, a plethoric complexion, a color that seems too high is often clinically significant. Many patients with hypertension look too healthy. Characteristically, patients with polycythemia vera seem to be in the pink of health. They exhibit a ruddy, slightly cyanotic hue most marked in the lips and ears, and often in the hands. If such bluish-red coloration is seen, confirmation that the abnormal hue is due to vascular engorgement may be had by inspecting the conjunctivae where vessels will be seen to be prominent and by noting a similar deep color of the mucous membranes. A hemoglobin determination and red blood cell count are then indicated. Hemoglobin over 18 grams or a red blood cell count over 6,000,000 per cmm. when accompanied by high facial color necessitates medical examination. The physician will, among other things, seek for enlargement of the spleen and perform more complete laboratory studies including a hematocrit determination. Patients with polycythemia are prone to thrombi formation and tend to bleed vigorously following surgical procedures such as tooth extraction. Paradoxically, the hemorrhage may benefit the patient by reducing blood volume. However, the dentist will be less uncom-

fortable if he knows the cause of the active bleeding beforehand.

Polycythemia vera is now treated with radioactive phosphorous, P_{32}, which induces remissions for from several months to several years. The dental consultant whose keen observation leads to earlier diagnosis and treatment of this disorder helps avert one or more serious episodes of thrombosis, to say nothing of hemorrhage while in the dentist's chair. In any event every patient who is plethoric should consult a physician if he has not done so in the recent past.

Search for systemic disease in the areas accessible to the oral diagnostician does not end with simple inspection of the face. Palpation of the neck has its place in dental medicine. Enlarged glands may indicate simple adenopathy due to local infection anywhere in the mouth or they may be the first clue to a more serious disorder such as one of the malignant lymphomas. Tender lymph nodes, hard nodes and nodes matted together cannot be dismissed lightly. They may have a bearing on dental therapy, directly or indirectly. Enlargement of the thyroid gland has already been mentioned. Palpation of this organ should be a routine procedure for reasons stated previously. Marked neck pulsations and greatly distended veins also deserve investigation by a medical colleague. Such signs may lead to discovery of intrathoracic disease.

From these few examples of systemic diseases detectable by inspection and palpation it is clear that if the dental consultant examines areas other than the mouth with planned interest, signs will be found in many instances. The recognition of these abnormal signs is a good beginning toward contributions that dental medicine can make in preventing systemic disease from advancing to incurable stages.

A word about ordering laboratory tests. Most patients will readily accept a request for a urinalysis, hematological studies or blood chemistries if they believe these are requisite for diagnosis and treatment of a dental condition. However, they may react differently if laboratory tests are ordered solely for a suspected medical condition. But where such tests are necessary to strengthen suspicion of constitutional disease it is to the patient's interest to request them. Look upon preliminary laboratory tests as additional signs available to the dentist, not as means for medical diagnosis. The dentist who makes a habit of searching for systemic disease is practicing superior dental medicine when he orders a special test based on suspicion. Such a dentist is making a zealous effort to further preventive medicine by accumulating enough information to warrant referring the patient for complete medical investigation. At no time, however, can the laboratory test take the place of medical examination when signs suggest constitutional disorders.

THE ORAL CAVITY AND SYSTEMIC DISEASE

Let us turn to the oral cavity itself. May I assure you that I do not intend to recite long lists of systemic disorders that may manifest themselves in mouth symptoms and signs. Rather, I have selected a few diseases — illustrations only — of disorders that may be of interest to you because of new medical concepts concerning them, new diagnostic developments and new therapies.

Of the many abnormalities that appear on mucous membranes, pigmentation warrants special attention because of its frequent association with Addison's disease. It is the third most common symptom of Addison's disease and is present in 94% of fully developed cases. Excluding negroes and dark skinned races in which melanoplakia is not uncommon, the finding of pigmentation particularly on lips, gingivae, and tongue should suggest this disorder. If the patient is certain that the pigmentation has been present since childhood it is usually unimportant. If the pigmentation is either recent or has developed within the past several years it demands investigation. At our hospital, six of forty-six patients with Addison's disease developed pigmentation three or more years before any other

symptoms. One of them who noted a lapse of ten years between the time the pigmentation first appeared and the development of asthenia was a dentist. In another patient, characteristic pigmentation was present for eighteen years before signs of adrenal cortical deficiency developed. As a differential diagnostic feature, the oral consultant should not rely on pigmentation having been present "for a long time." Pigmentation may be of several forms and hues. It may be present as unshapely patches of brown, brown-gray, gray-black or blue-gray. It may appear as spots or streaks and even as a diffuse uniform pattern of darkness. The discovery of any of these varieties of pigmentation will direct attention to the exposed areas of the skin. The hand is a favorite site. It may be dark or the increased pigmentation may be seen only on the knuckles and in the creases of the fingers. Jet-black freckling may be found on the face or the complexion may reveal a diffuse tan, sun-tan, brown, smokey, or negroid coloration. Since lymphadenopathy is fairly common in this disease, palpate the neck for glands. Ask the patient about weakness and weight loss — symptoms that are present in the fully developed picture. If they are not present, Addison's disease is of course *not excluded;* the patient must, nonetheless, be referred for diagnostic examination.

It is possible today to make the diagnosis of Addison's disease before serious symptoms appear. The fundamental defect in this disorder is adrenal cortical deficiency resulting from either tuberculosis with destruction of the gland or from atrophy of unknown cause. Modern diagnostic technics are designed to test the integrity of the adrenal cortex and are relatively simple. The ACTH or adrenocorticotropic hormone test, for example, is a new, fairly specific method for determining adrenal cortical function. It is based on the observation that when the normal adrenal cortex is stimulated by pituitary ACTH there occurs an immediate fall in the circulating eosinophiles of the blood. The patient with Addison's disease shows little or no drop in eosinophiles after injection of ACTH.

Patients with Addison's disease do not tolerate illness or minor surgical procedures well unless deficiency has been corrected. Dental surgery is, therefore, contraindicated in a patient suspected of adrenocortical insufficiency. Modern treatment consists of replacement therapy with either desoxycorticosterone acetate, adrenal cortex extract, cortisone or combinations of these compounds.

Proceeding now to the periodontal structures for further illustration of how dental medicine can prevent or detect systemic diseases one finds a host of possible disorders. To quote Miller* who has aptly summarized the situation "In periodontal diseases, the etiology is complex. . . . There is no one cause, which, alone is capable of producing the disease. The rationale of treatment must include . . . the discovery and removal of the initiating or causative factors and the raising of tissue resistance. The balancing of occlusion and proper gingival massage by the toothbrush, together with instrumentation and the removal of gingival irritants, usually suffices for the local treatment. However, the dentist's responsibility does not end there. In many cases it must include advice on diet, complete blood examination for discovery of polycythemia, anemia, leukemia, leukopenia and other conditions. The dentist must, as well, be able to render assistance to the physician in the discovery of systemic diseases such as diabetes, syphilis, tuberculosis. Cooperation with the physician is of utmost importance, both in obtaining the above information and in uncovering any general conditions traceable to foci of infection." Admittedly, this is no small order. However, if it is remembered, that periodontal disease is present in a great many diabetic cases and is one of its diagnostic features, the role of the dentist in detecting diabetes mellitus is seen to be of primary importance.

A few years ago a survey designed to

* Miller, S. C.: Oral Diagnosis and Treatment Planning, The Blakiston Co., Phila., 1946, p. 245.

determine the incidence of diabetes mellitus in the population was conducted in Oxford, Massachusettes. The urine of every member of the community was examined. It was found that for every known diabetic there existed another diabetic unaware of his illness. Since it has been estimated that there are approximately one million known diabetics in the United States at the present time, one million more persons with diabetes remain to be discovered. While dentists are not in the same position as physicians to perform routine urinalyses it is mandatory that every patient with periodontoclasia be requested to have his urine examined.

Other oral signs and symptoms of diabetes that may come to the attention of the dentist first are complaints of dryness of the mouth and thirst. Every patient with such complaints should be asked whether or not urinary frequency, both diurnal and nocturnal are also present since the thirst bears a direct relation to the polyuria. Additional dental signs that are not infrequent in diabetics are sudden loosening of the teeth, almost overnight, as it were; frequent formation of salivary calculi; and the frequent occurrence of dry sockets. In the event any of these abnormalities are noted, urinalysis should be ordered. In this way dental medicine can do much to further preventive medicine as well as preventive dentistry in this field.

When periodnntoclasia is found, hematology studies are also necessary, especially if a bleeding tendency is associated. Finally, advice on diet is an integral part of systemic therapy of periodontitis and every dentist undertaking treatment should be prepared to render such advice. Here, perhaps more than in any other field of dental disease, a balanced diet with adequate intake of vitamins C and D is essential for success. In attaining this success the dentist will be promoting good nutrition for his patient.

Another group of systemic disorders is detectable by x-ray examination of the teeth and jaws. Since radiography has become a routine phase of dental examination there is little doubt that the dentist is usually the first one to detect most bone involvement in this area. As with other constitutional diseases that come within the ken of the dentist, he must keep his mind prepared for x-ray manifestations of disease other than simple dental lesions such as caries, alveolar abscesses and impacted teeth. Again, he should study the radiographs with planned interest — with a view to detecting systemic disorders.

One systemic disorder that the oral diagnostician may suspect long before the physician is hyperparathyroidism. This is not a rare metabolic disorder as was formerly believed. It is common, and it may exist for years before producing symptoms that force the patient to seek attention. The dentist sees that phase of the disease which involves the skeleton, the well known generalized osteitis fibrosa cystica or von Recklinghausen's disease. This is but one manifestation of hyperparathyroidism. Other aspects are involvement of the kidney with calculi and gastrointestinal symptoms. Some patients exhibit abnormalities related only to the osseous system, others exhibit urinary tract symptoms exclusively. Because the underlying hyperparathyroidism is easily correctable by surgery, early diagnosis before irreversible kidney damage has occurred is imperative.

Most cases of hyperparathyroidism are due to an adenoma, almost always benign, of one of the four parathyroid glands. Less commonly, overproduction of parathyroid hormone is due to a diffuse hyperplasia of all of the glands. It is now generally accepted that the pathologic physiology resulting in osteitis fibrosa begins with excessive loss of phosphorous in the urine as a direct consequence of too much hormone. This in turn decreases the serum phosphorous level. In an effort to maintain the serum phosphorous near normal levels, phosphorous is released from bone and with it calcium. As a result the serum calcium level is elevated. In an effort to rid the serum of its high calcium content, calcium is excreted in excess into the urine.

The bones thus become depleted and decalcified; bone resorption is excessive. Simultaneously, the bone which is a living dynamic tissue, not an inert structure, attempts to strengthen itself with fibrous tissue and new bone formation. Whenever this occurs, serum alkaline phosphatase rises. However, bone formation never quite keeps pace with bone resorption, with resulting osteoporosis, cyst formation, increased fibrous tissue and giant cell tumors. These latter may take the form of an epulis of the jaw.

Dental radiographs often give the first clues, namely absence of the lamina dura, bone cysts and giant-cell tumors. The absence of the lamina dura is always indicative of pathology and signalizes generalized osteoporosis due to some metabolic disturbance. It should be mentioned that x-ray evidence of osteitis fibrosa is not pathognomonic of von Recklinghausen's disease. This type of fibrous reaction is actually a nonspecific reaction due to rapid resorption of bone and occurs in several bone diseases. In any event, the dentist who discovers osteitis fibrosa and absent lamina dura can be certain that a metabolic bone disorder is present and that it is most likely due to hyperparathyroidism. Differential diagnosis will be made by complete physical examination, x-ray examination of other areas, biochemical studies of the blood and calcium balance studies. Additionally, the jaw may become so soft that the teeth fall out. However, while the skeleton is becoming decalcified there is no decalcification of the tooth itself.

Another metabolic bone disorder which the dentist will diagnose is Paget's disease (osteitis deformans). The characteristic dental x-ray feature is hypercementosis. Teeth roots become thickened and club-shaped instead of tapering gracefully. In the jaw, radiolucent areas may appear. Paget's disease is a fairly common disorder. It is said to be present in 3 per cent of all persons over forty years of age. Like patients with hyperparathyroidism, these patients are subject to renal calculi; and in addition, quite commonly develop osteogenic sarcoma later in life. Early treatment with calcium, phosphorous, vitamin D, and in the case of postmenopausal women, administration of estrogens, will do much to avoid complications which can lead to premature death.

SUMMARY

It is apparent that dental medicine has much to offer patients by way of detecting and preventing systemic diseases. The greatest contributions will be made by those members of the profession who maintain a broader view of the functions of the dentist. These functions include searching for systemic disease in areas that are always accessible — the face, neck and often the arms and hands. Included also is the necessity for searching diligently for systemic disease within the mouth. This should be done with planned interest, an interest that extends beyond the immediate dental problem. Any suspicious evidence that a constitutional illness may exist is to be pursued by collecting more signs, by taking appropriate measures to strengthen the suspicion and by referring the patient to a medical colleague. A freer use of simple laboratory tests is also indicated — not for the purpose of making a medical diagnosis, since this rests with the physician, but in order to accumulate more signs.

A few systemic disorders, detectable both within and outside of the mouth by the alert dentist have been suggested by way of illustration. It is hoped that these illustrations will help to emphasize the great potenial in dentistry for furthering preventive medicine.

133 East 58th Street

A VISUALIZED TECHNIQUE OF OCCLUSAL EQUILIBRATION

LAWRENCE A. WEINBERG, B.A.*

The object of this article is the visual presentation of the principles of occlusal equilibration based on the procedures in "The Textbook of Periodontia" (1) the chapter, "Traumatic Occlusion; Its Detection and Correction," (2) and the work of Schuyler.

I. PRELIMINARY GRINDING
A. OCCLUSAL PLANE
1) Improve esthetics. (Fig. 1)

FIG 1

2) Reduce leverage by reducing cusp inclines of the posterior teeth. (Fig. 2)

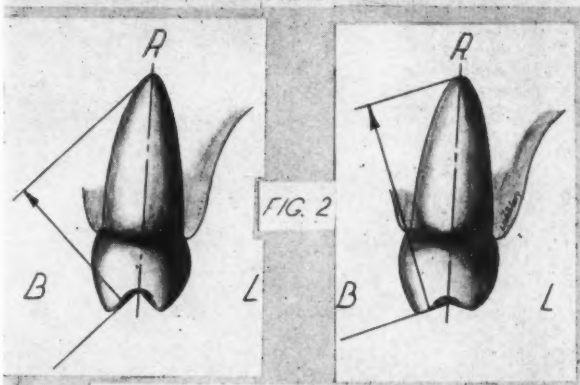


FIG. 2

3) Reshape cusps of teeth elevated beyond the occlusal plane. (Fig. 3)

FIG. 3

4) Reshape tilted teeth. (Figs. 4, 5)

FIG. 4

FIG. 5

5) Correct marginal ridges of rotated teeth (see Fig. 9). (Fig. 6)

FIG. 6

Unequal Marginal Ridges

6) Furnish operative restorations to correct occlusal effects of bucco- or linguo-version (see Figs. 72-77 and Figs. 68-71). (Figs. 7, 7A)

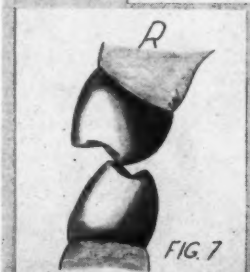


FIG. 7

Buccal Version

FIG. 7A

Lingual Version

* Senior Student at N.Y.U. College of Dentistry (illustrations done by author).

B. RELIEF OF FOOD IMPACTION

1) Check on proper location of contact points. (Fig. 8)

FIG. 8

2) Restore marginal ridges to the same plane. (Fig. 9)

3) Restore proper anatomy by grinding in occlusal grooves. (Fig. 10)

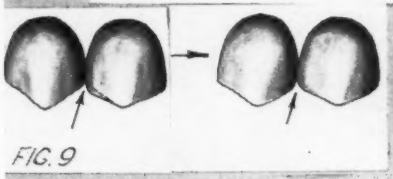


FIG. 9

FIG. 10

4) Eliminate plunger cusps. (Fig. 11)

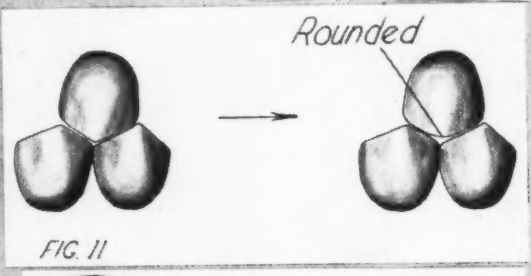


FIG. 11

5) Furnish operative restorations to restore contact points, marginal ridges and anatomy. (Fig. 12)

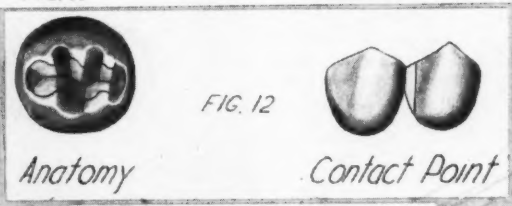


FIG. 12

C. RESHAPING ABNORMALLY WORN TEETH

1) Reduce bucco-lingual width. (Fig. 13)

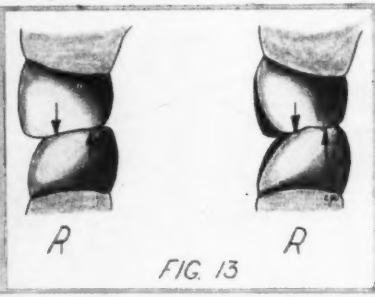


FIG. 13

2) Restore anatomy in harmony with age and peridontal resistance. (Fig. 14, 14a)

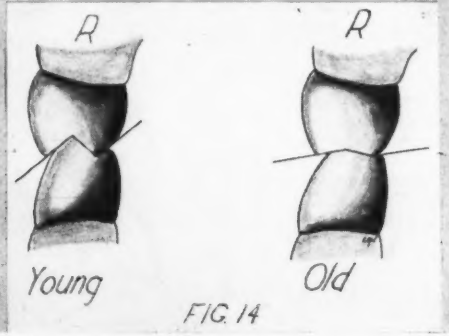
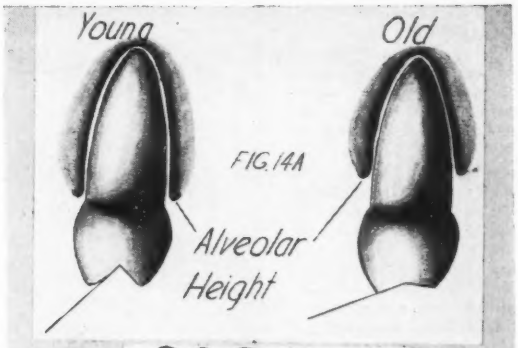
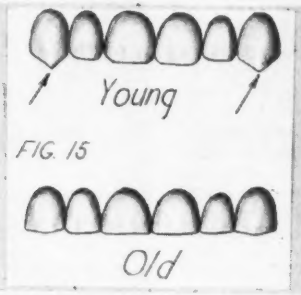


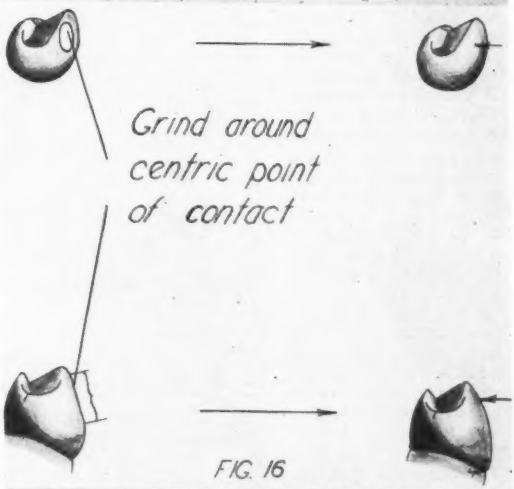
FIG. 14



3) Reduce sharp corners of anterior teeth. (Fig. 15)



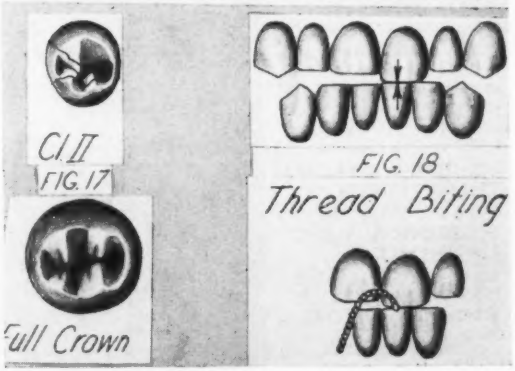
4) Remove facets of wear. (Fig. 16)



5) Furnish operative restorations to restore anatomy compatible with age (see Fig. 14, 14a). (Fig. 17)

D. ELIMINATION OF ABNORMAL HABITS

1) Positive suggestion or by grinding: Grind upper left central to eliminate prematurity in protrusive. (Fig. 18)



II. CENTRIC OCCLUSION

A. DIAGNOSIS: Instrument may be used with the aid of wax bite records, study casts, articulating paper, patient's tactile sense and operator's observation or tactile sense. (Fig. 19)

B. MAINTENANCE OF VERTICAL DIMENSION Corrective grinding of the buccal cusp incline of the upper and the lingual cusp incline of the lower does not change the verticle dimension (in normal buccolingual relationships). (Fig. 20)

C. IF PREMATURITY is present in anterior segment grind the lower anterior teeth in the following situations:

1) MARKED OVERBITE: When most of the labial surface of the lower anterior is in contact with the lingual of the upper, grinding is done on the lower from the lowest point of centric contact (arrows), incisally. Since the incisal has no contact with the lingual of the upper, the the lower can be shortened considerably if possible and necessary. (Figs. 21 and 22)

2) MARKED OVERBITE with the lower incisal edges touching the gingiva. Correct protrusive relation must be secured to prevent elevation of the lower anterior teeth into their original position. (Fig. 23)

3) WHEN THE LIMIT OF GRINDING HAS BEEN REACHED ON THE UPPER for esthetics or sensitivity. Excessive grinding of teeth produces unesthetic results. (Fig. 24)

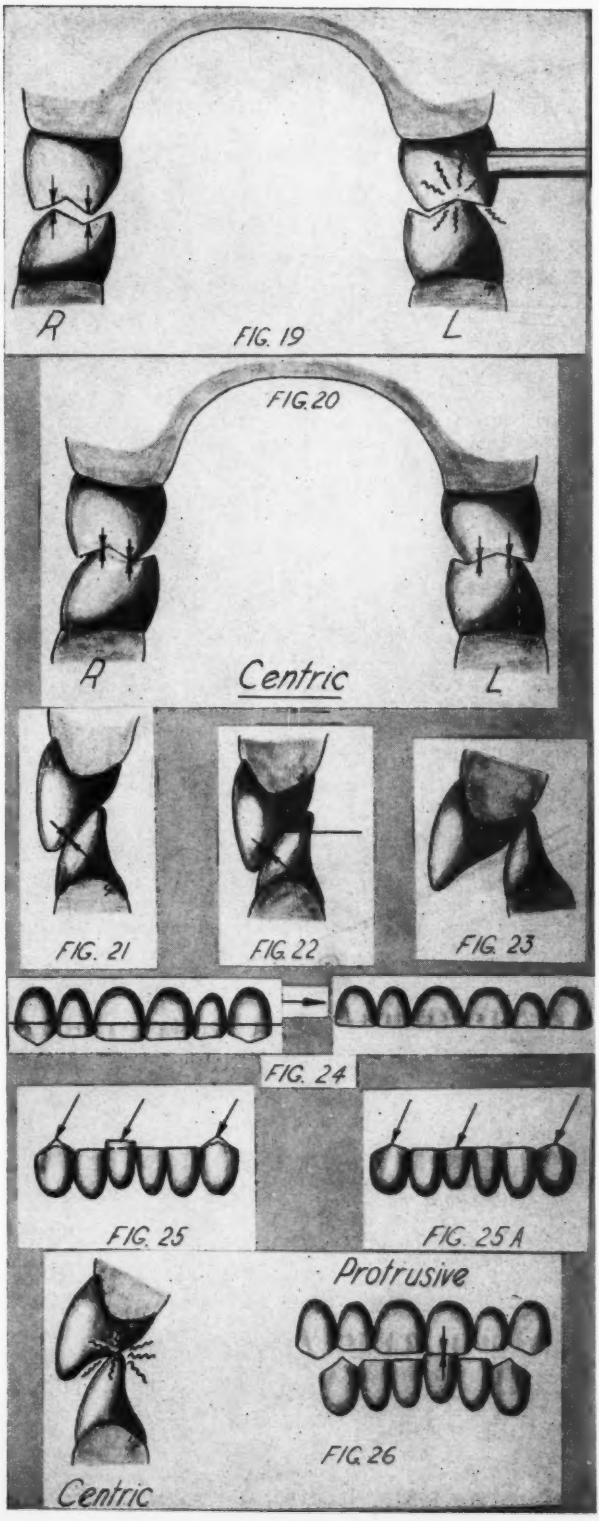
4) To disocclude markedly mobile anterior teeth.

5) IN REPOSITIONING THE MANDIBLE for better function, as in false mesial occlusion, it may be necessary to grind the upper and the lower incisal surfaces.

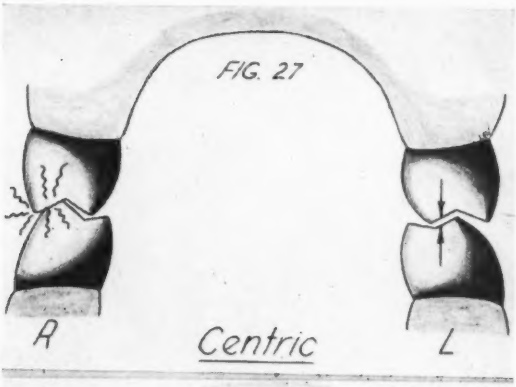
6) TO IMPROVE ESTHETICS OF LOWER. (Figs. 25 and 25a)

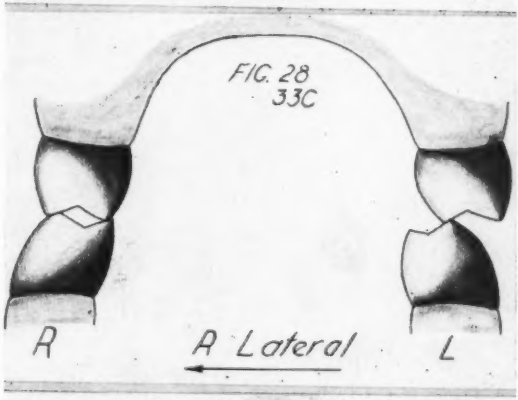
7) TO PREVENT HABIT (see Fig. 18).

8) WHEN A PREMATURITY IN CENTRIC AS WELL AS PROTRUSIVE IS PRESENT. (Fig. 26)

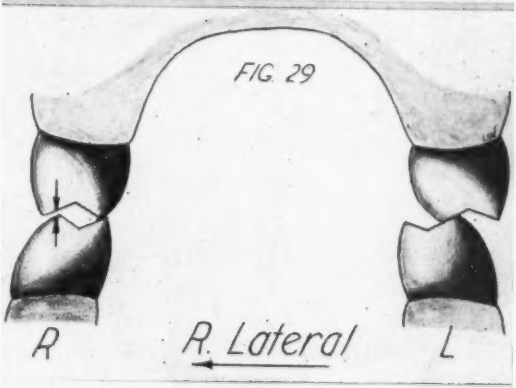


D. GRIND FOSSA OF THE UPPER if the lower buccal cusp is in premature contact in centric (Fig. 27) but in harmony in lateral (Fig. 28) to maintain centric contact.

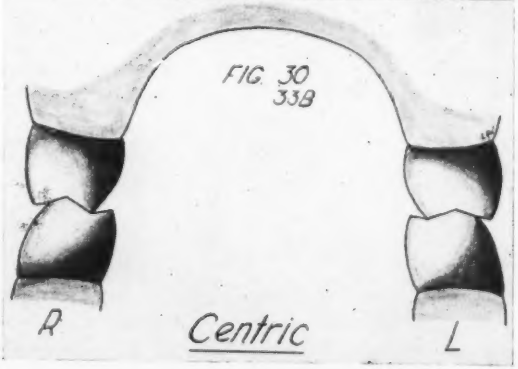




1) GRINDING THE LOWER BUCCAL CUSP removes it from contact in lateral. (Fig. 29)



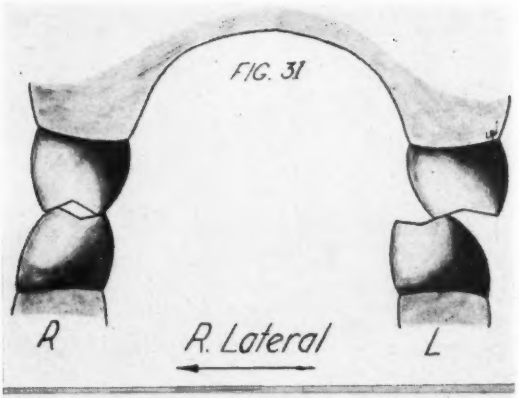
2) THE FOSSA OF THE UPPER IS REDUCED to eliminate prematurity. (Figs. 30, 31)

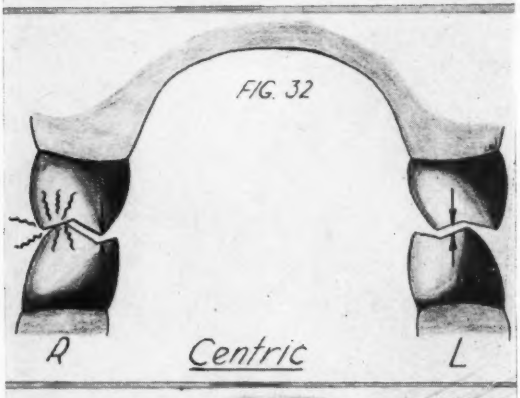


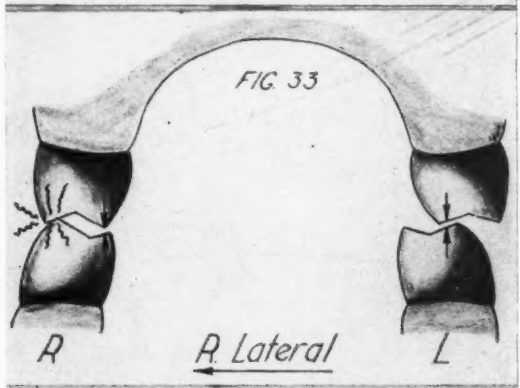
E. GRIND THE BUCCAL CUSP OF THE LOWER

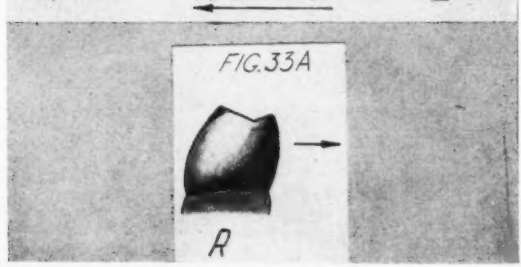
(Fig. 33A) if it is in premature contact in centric (Fig. 32) as well as in lateral. (Fig. 33)

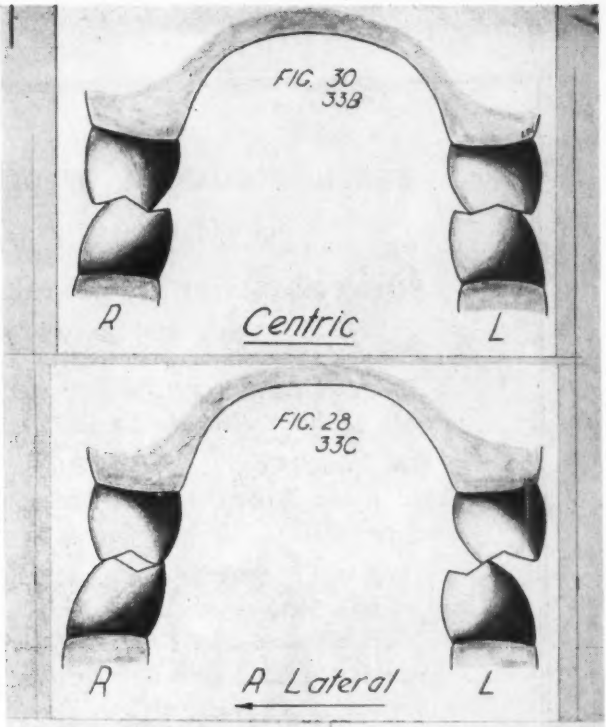
Results of corrective grinding shown in Fig. 33B, C.





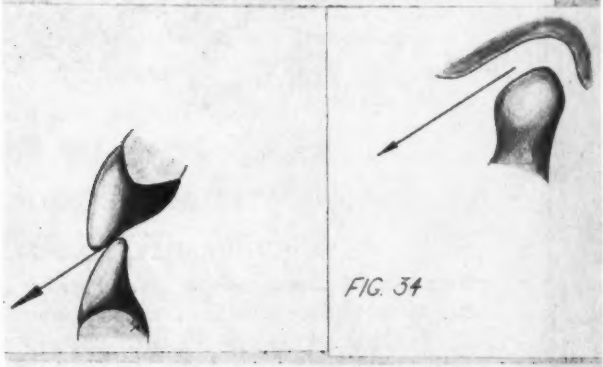




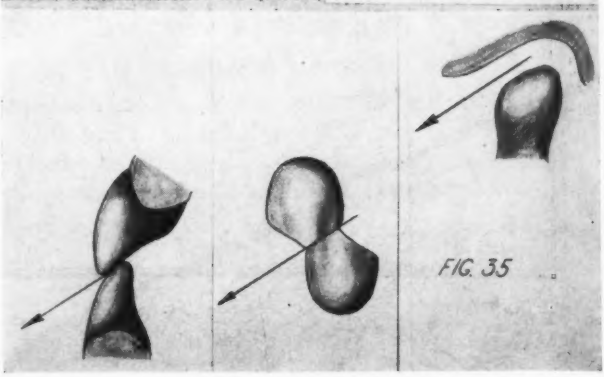


III. PROTRUSIVE RELATIONSHIPS

A. PROTRUSIVE is guided by the anterior posterior incline of the glenoid fossa (condylar path) and the anterior tooth guidance. (2) (Fig. 34)



B. OPTIMUM PROTRUSIVE RELATIONSHIP: The optimum situation would be to have the anterior tooth guidance, the posterior inclines, and condylar path all at the same angulation in their own planes. (2) (Fig. 35)



AMERICAN ACADEMY OF DENTAL MEDICINE

Sixth Annual Meeting

MOUNT ROYAL HOTEL, MONTREAL, P. Q., CANADA

May 29, 30, 31, 1952

The Montreal section is hard at work preparing for the first meeting of the Academy in Canada.

The splendid facilities of the Mount Royal Hotel have been placed at our disposal and a fine scientific and social program is being prepared.

There will be three days of planned activity which will include two scientific sessions, two dinners, two luncheons, a cocktail party, and tours of the beautiful City of Montreal and of the popular Laurentian Mountain area. The Province of Quebec is at its best at this time of the year.

The meeting will be held on dates which will include Memorial Day.

Plan Your Spring Vacation
To Include This Meeting

TENTATIVE PROGRAM

THURSDAY, MAY 29, 1952

9 a.m. to 12 noon	Registered Clinics
2 p.m. to 5 p.m.	Registered Clinics
Up to 6 p.m.	Official Registration time for meeting
7:30 p.m.	Dinner Party—Entertainment

FRIDAY, MAY 30, 1952

10 a.m. to 1 p.m.	Business Meeting
2:30 p.m. to 5 p.m.	Scientific Session—Essays
6:30 p.m.	Cocktail Party
7:30 p.m.	Dinner—Awards to Honorary Members

TENTATIVE PROGRAM

SATURDAY, MAY 31, 1952

10 a.m. to 1 p.m.	Scientific Session—Clinics
1 p.m. to 2:30 p.m.	Luncheon—Academy Awards
2:30 p.m.	Sightseeing Tours
6 p.m.	Official Hotel checking out time

Further information on registered clinics will be mailed to you soon.

Rooms with Bath are available as follows:

Singles starting at $6.50 daily
Doubles starting at $3.00 daily
Extra cot in room $3.00 daily

ESTIMATED COST PER COUPLE

Registration Fee—Members	$25.00
Ladies	$20.00
Non-members	$30.00
Double room—2 nights—maximum	$21.00
Extra breakfasts (4) per couple	$ 6.00
Total	$72.00

* Registration fee includes scientific sessions (except registered clinics), 2 dinners, 2 luncheons, and cocktail party.

A wonderful week-end is in store for you and your family, bring the children; provisions are being made for sitters and entertainment for the kids.

MONTREAL HOSPITALITY AWAITS YOU
MAKE YOUR RESERVATION NOW! ! ! !

"WIL" JOHNSTON
"AL" LAFERRIERE
"HY" PEARSON

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C. CORRECTION OF PROTRUSIVE RELATION:

1) ESTHETICS OF UPPER TEETH IS ESTABLISHED and simultaneous contact of anterior teeth from canine to canine is gained, if it is possible without extreme grinding. (See Figs. 36, 37)

2) GRIND LOWER ANTERIOR TEETH TO ESTABLISHED PLANE OF THE UPPER (see Figs. 21-26 for indications for grinding the lower anterior teeth.) (Fig. 37)

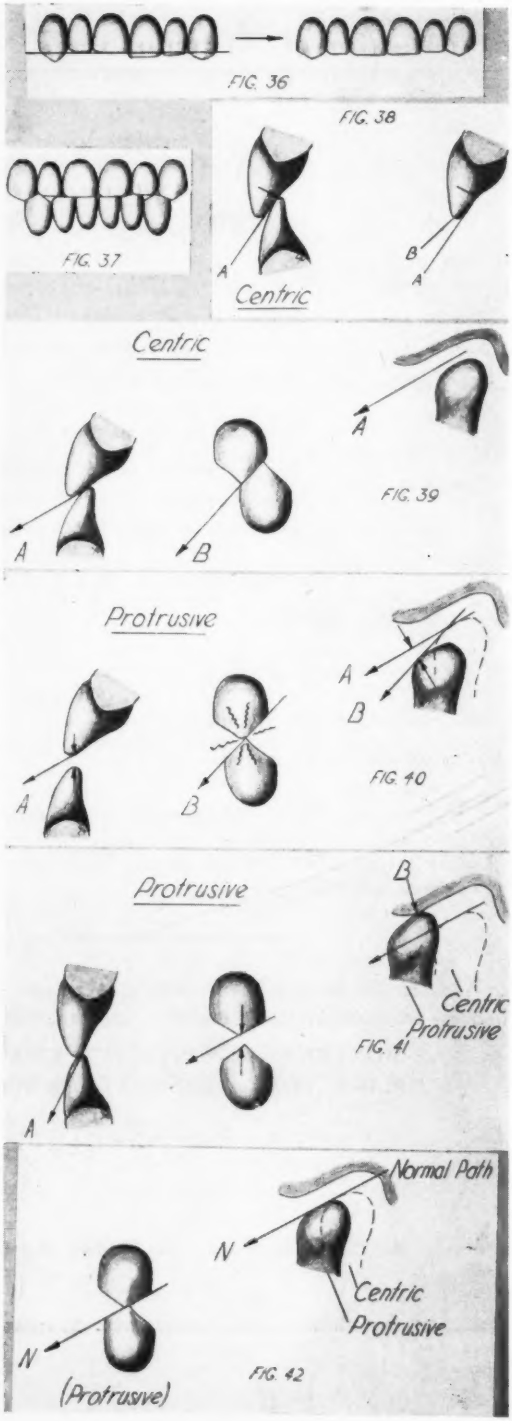
3) TO MAINTAIN CENTRIC CONTACT: In excursions, if prematurities are present in anterior, grind the lingual of the upper teeth from the point of centric contact (but not including it) arrow Fig. 38, to the incisal edge. (B Fig. 38)

D. PROTRUSIVE EXCURSION

1) Favorable distribution of forces in protrusive depends upon whether or not the occlusal inclines of the posterior teeth harmonize with the two extreme guiding factors; (the anterior tooth inclines and the condylar path are shown in Fig. 34). (2)
   A. Normal incisal and condylar path.
   B. Steep incline of posterior teeth. (Figs. 39, 40)

2) EXCESSIVE INCLINATION OF THE GUIDING INCLINES OF THE ANTERIOR TEETH may induce compressive wear of the meniscus and articulating surfaces of the joint from muscle action due to lack of functional contact of the posterior teeth in eccentric relations. (2) (Fig. 41)

3) EXCESSIVE INCLINATION OF THE GUIDING INCLINES OF THE POSTERIOR TEETH (A Fig. 43) or interfering posterior tooth surfaces in centric or eccentric may place a strain on the capsule and ligaments of the joint (arrows Fig. 43) due to the downward pull on the condyle head. (2) (Figs. 42, 43)



IV. LATERAL EXCURSIONS

A. IF ANTERIOR TEETH INTERFERE, grind the lingual of the upper teeth from (BUT not including) centric point of contact to the incisal. (See Fig. 38)

B. IF CUSPIDS INTERFERE grind the lingual of the upper cuspids from the centric point of contact incisally to harmonize with the posterior guiding inclines.

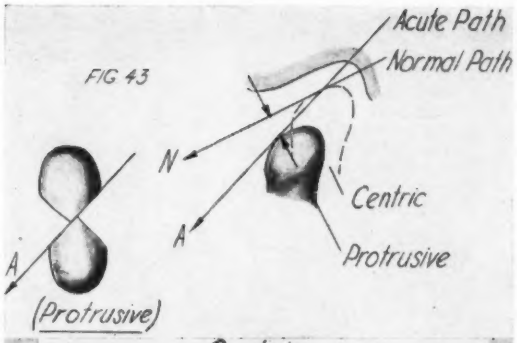
C. UNEQUAL STRESS IN ECCENTRIC RELATIONS is usually due to dissimilar inclines rather than cusp points. *The same side of the mouth will be considered here.*

1) UNEQUAL STRESS is caused by lateral guiding inclines of the posterior teeth which are more acute than the adjacent teeth as in Fig. 44 right premolar. (2)

2) RIGHT LATERAL POSITION shows the premolar bearing excessive strain and the molar out of contact. (2) (Fig. 45)

3) CORRECTIVE GRINDING on the buccal cusp incline of the upper and the lingual cusp incline of the lower (premolar) will make all the guiding inclines harmonious and relieve stress. (2) (Fig. 46)

4) DISTRIBUTION OF STRESS AND FUNCTIONAL EFFICIENCY WILL result if corrective grinding is accomplished in this manner. (2) (Fig. 47)



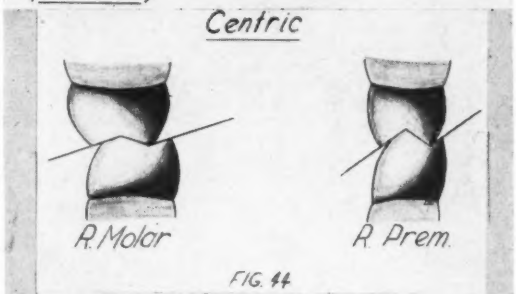


FIG. 44

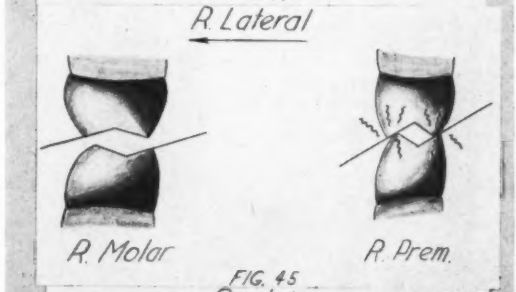


FIG. 45

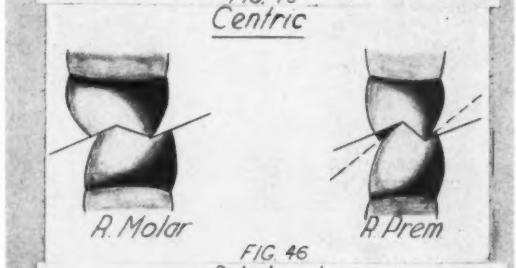


FIG. 46

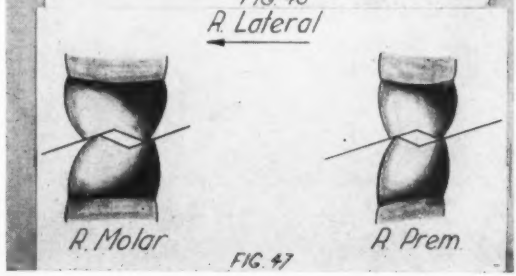


FIG. 47

5) INCORRECT GRINDING OF THE BUCCAL CUSP OF THE LOWER OR LINGUAL CUSP OF THE UPPER removes the proper static contact. (Centric) (2) (Fig. 48)

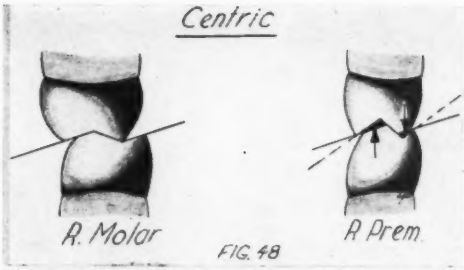


FIG. 48

6) THESE CUSP POINTS (R. Premolar) are taken out of centric relation (Fig. 48) and functional efficiency (Fig. 49) and place undue strain on the adjacent teeth. (2)

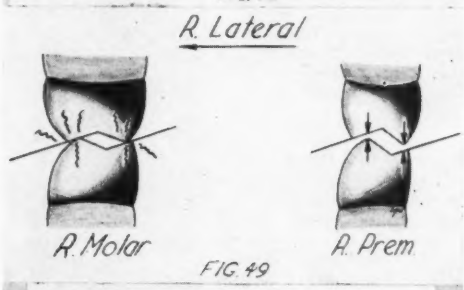


FIG. 49

D. WORKING SIDE
1) TOOTH AREAS OF POSSIBLE TRAUMA IN LATERAL (right lateral shown.) (Fig. 50A)

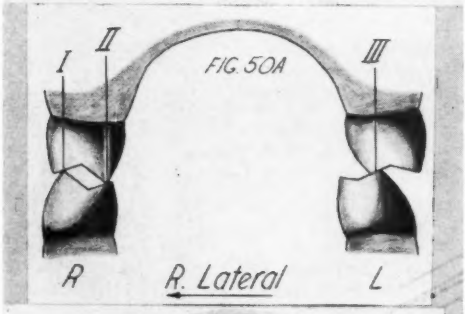


FIG. 50A

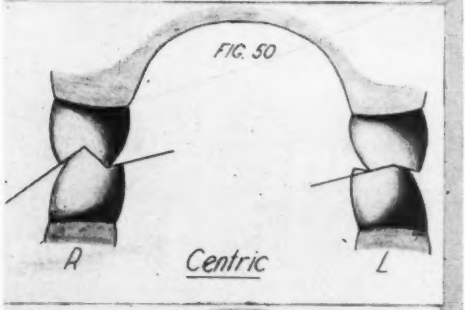


FIG. 50

2) PREMATURE CONTACT OF THE UPPER BUCCAL CUSP and the lower buccal cusp in lateral excursion. (Area I in Fig. 50A) (Figs. 50, 51)

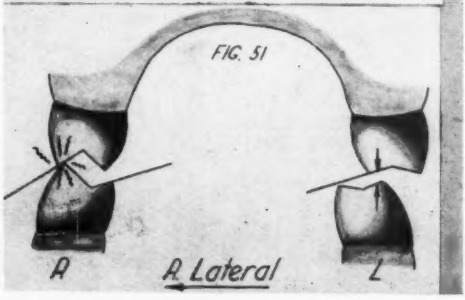
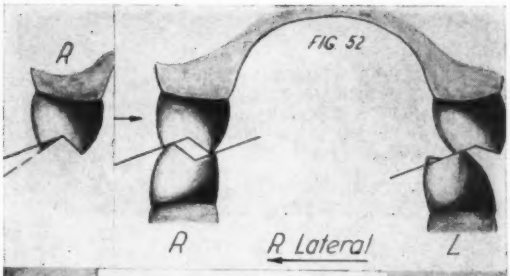
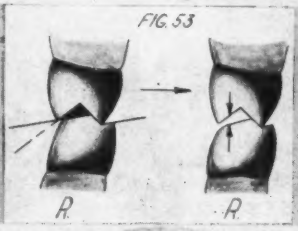


FIG. 51

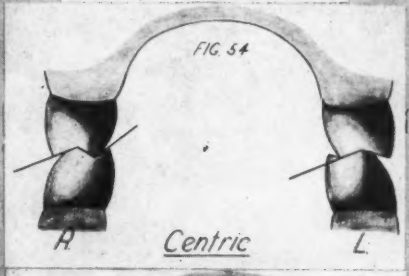
a. **CORRECTIVE GRINDING** is done on the buccal cusp incline of the upper from the point of centric contact (but not including it.) (Fig. 52)

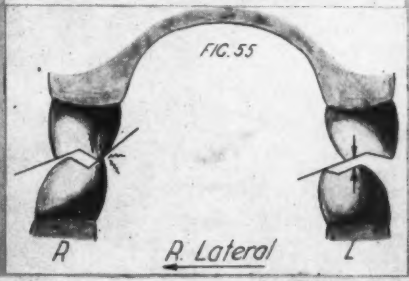


b. **GRINDING THE LOWER BUCCAL CUSP RESULTS** in loss of centric contact. (Fig. 53)

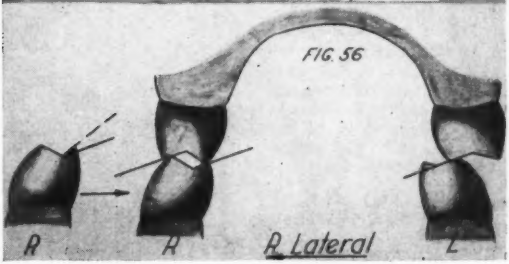


3) **UPPER LINGUAL PREMATURITY** with the lower lingual cusp on working side. (Area II in Fig. 50A) (Figs. 54, 55)





a. **CORRECTIVE GRINDING** is done on the lingual cusp incline of the lower from the point of centric contact (but not including it.) (Fig. 56)



b. IMPROPER GRINDING OF THE UPPER LINGUAL CUSP causes the loss of centric contact. (Fig. 57)

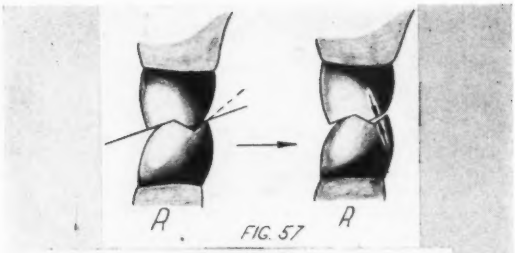


FIG. 57

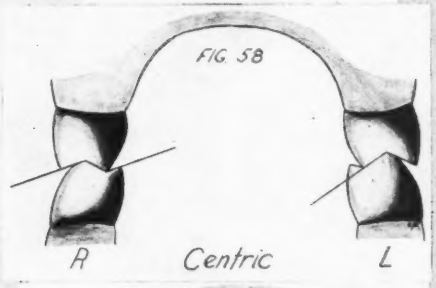


FIG. 58

E. BALANCING SIDE (Area III in Fig. 50A)

1) EXCESSIVE CONTACT ON BALANCING SIDE. (Fig. 58, 59).

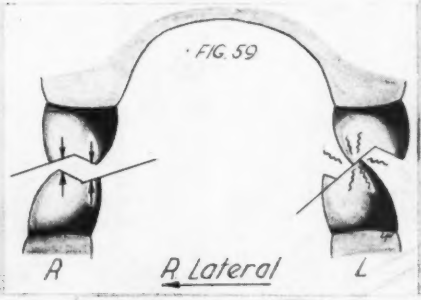


FIG. 59

2) CORRECTIVE GRINDING may relieve the condition by reducing the occusal incline of the lower buccal cusp without altering the centric contact. (Fig. 60)

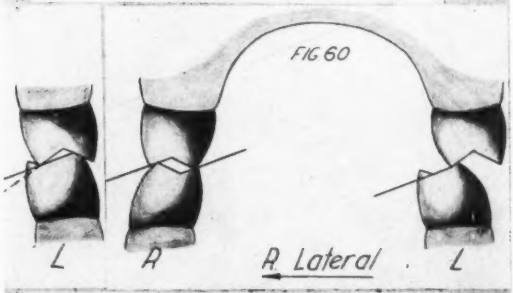


FIG. 60

3) TO CORRECT TRAUMA it may be necessary to sacrifice either the upper lingual or the lower buccal cusp which would interfere with centric. The other cusp, in this case, must be meticulously maintained.

a. THE LINGUAL CUSP OF THE UPPER MAY HAVE NO CONTACT WITH the lower in centric (Fig. 61) or on the working side (Fig. 62)

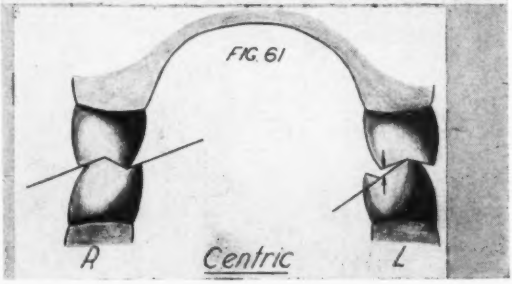
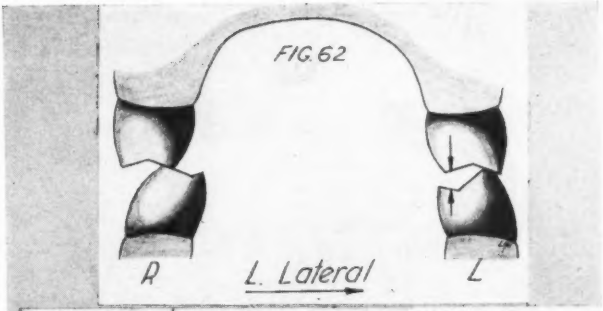
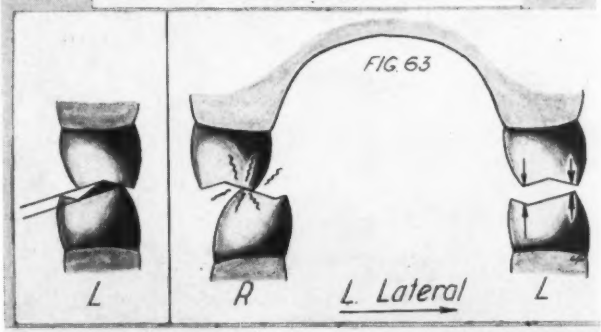


FIG. 61

In this case corrective grinding is done on the upper lingual cusp; the rationale being that it would not disturb centric nor the working side since it does not function in those positions *before* correction.

b. GRINDING THE LOWER BUCCAL CUSP would reduce the efficiency on that side in eccentric relation (working side) and cause excessive strain on the opposite side. Rather than correct the original trauma it would induce the same fault on the opposite balancing side. (Fig. 63)



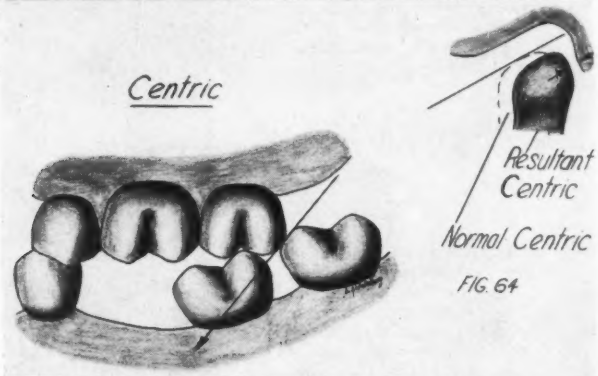


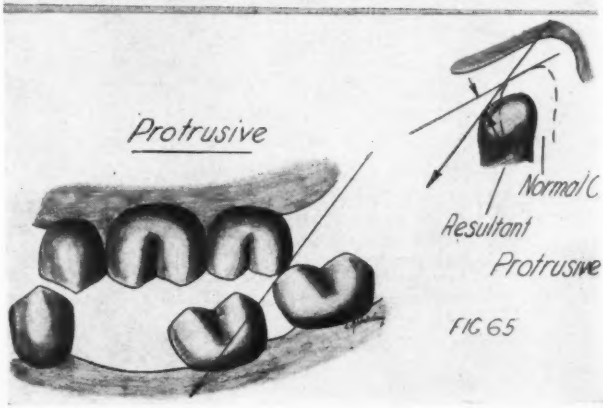
V. CENTRIC OCCLUSION CHECKUP

VI. SMOOTHING OF GROUND SURFACES

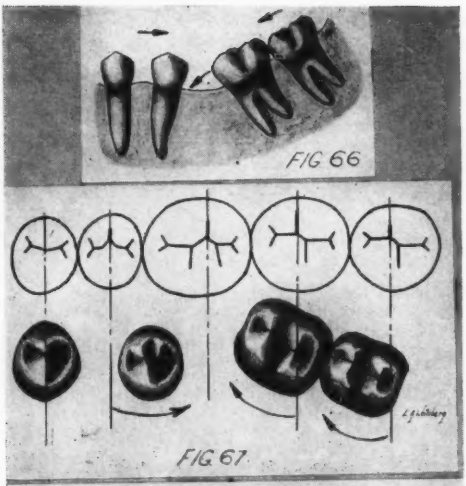
VII. COMPLICATIONS CAUSED BY LOSS OF TEETH

A. Changes in occlusal relationships due to the loss of teeth and drifting (Fig. 64) can cause strain on the temporomandibular ligaments. (Fig. 65) (2)

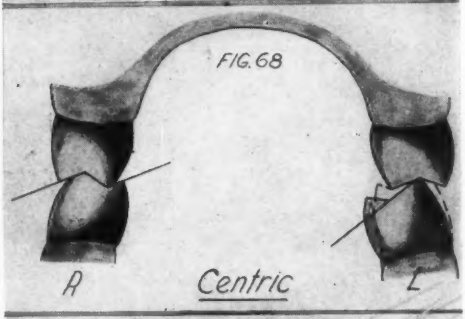




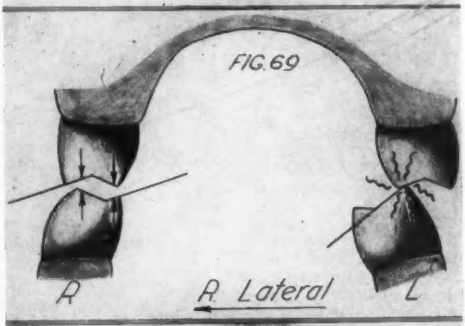
B. **PREMATURITY ON BALANCING SIDE** often results where the first lower molar is lost and the second and third molars drift into a mesiolingual position. (2) (Figs. 66, 67)



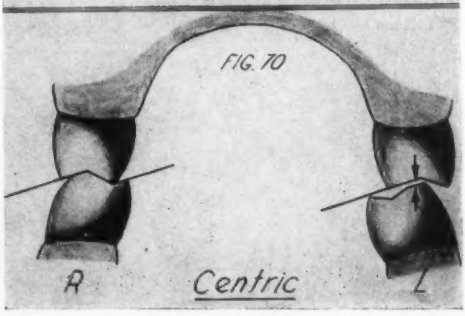
1) This increases the angles of the balancing inclines (left, Fig. 68) and predisposes them to trauma while the bolus of food is masticated on the opposite side. (Fig. 69) (2)



2) If there is no premature contact in centric all corrective grinding to relieve trauma in eccentric position must be confined to the upper tooth. (Fig. 69) (2) (See Figs. 61, 62 for rationale.)



3) If the **LOWER BUCCAL CUSP IS GROUND** no centric contact will result and the tooth will elevate producing the original trauma. (2) (Fig. 70)



4) CORRECTIVE GRINDING should be done on the upper lingual cusp incline. (Fig. 71) (See "Excessive contact on balancing side" for rationale. Figs. 58-63) (2)

VIII. TIPPING OF TEETH (Buccally and Lingually)

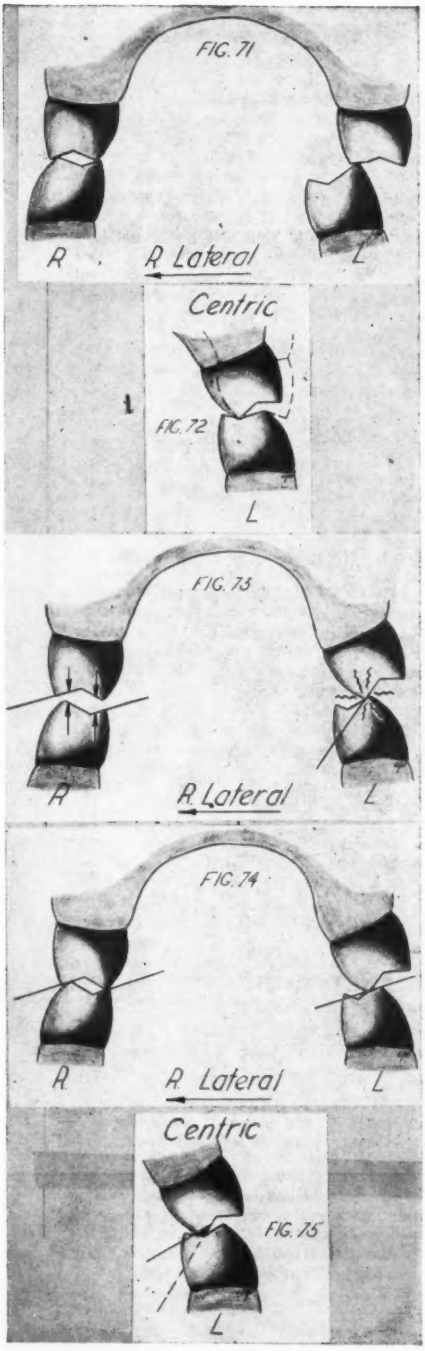
A. BUCCAL INCLINATION: Due to the excessive buccal inclination of the upper molar tooth, there may be no centric contact of the upper buccal cusp inclines or fossa with the lower buccal cusp. (2) (Fig. 72)

B. ALL CORRECTIVE GRINDING for the elimination of the trauma in eccentric relations must be done on the lower tooth since the upper lingual cusp is the only part of the upper tooth that maintains centric. (2) (Fig. 73)

1) CORRECTIVE GRINDING IS DONE ON THE LOWER BUCCAL CUSP INCLINE. (Fig. 74) (See "Excessive contact on the balancing side" Figs. 58-63 for rationale.) (2)

2) GRINDING THE UPPER LINGUAL CUSP would result in:

a. IMPAIRED FUNCTIONAL ECCENTRIC ON THE WORKING SIDE. (Figs. 75, 76)

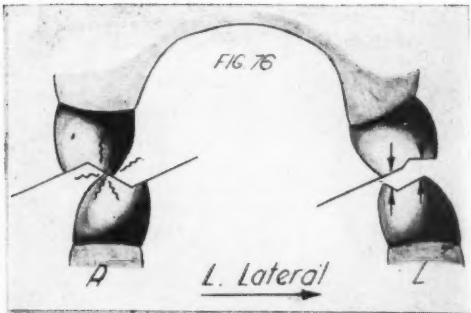


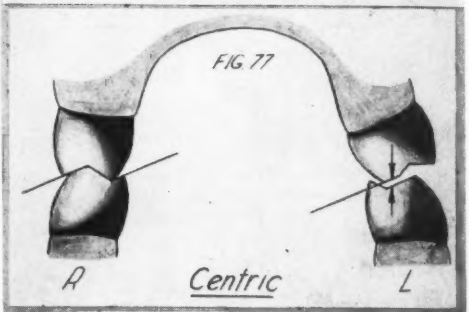
b. ELEVATION OF THE TOOTH DUE TO LACK OF CENTRIC CONTACT would develop thus producing the original trauma. (2) (Fig. 77)

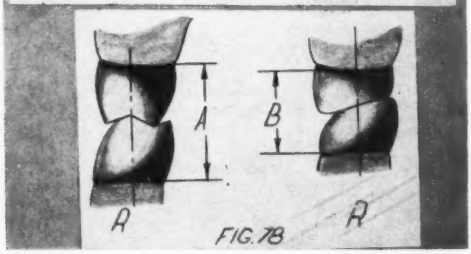
IX. WEAR, CAUSING LOSS OF VERTICAL HEIGHT and possible injury to the temporomandibular joint. (2) (Figs. 78, 79, 80)

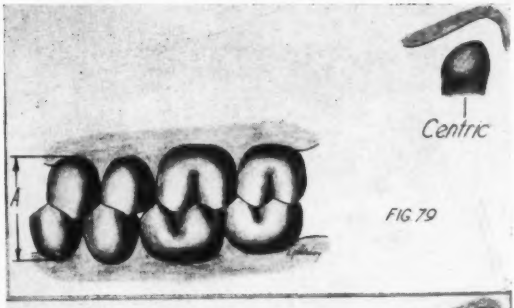
(A) Proper vertical height.

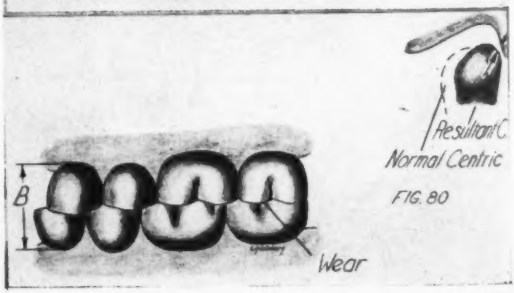
(B) Reduced vertical height (condyle driven posteriorly, Fig. 80.)











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The author wishes to express his sincere thanks to Dr. J. Lewis Blass for his guidance and aid in the planning and writing of this article and to Dr. Clyde H. Schuyler for the permission of the use of material.

BOOK REVIEWS

Diseases of the Endocrine Glands. By Louis J. Soffer, M.D., F.A.C.P., Philadelphia, Pa., Lea & Febiger, 1951. 1142 pp. 88 ills. $15.00.

Endocrinology is assuming great importance in clinical medicine. Its limitation in the past to specific endocrine diseases no longer maintains, for a glandular dysfunction plays a determining role in many illnesses and pathologic processes. The author has, therefore, attempted to view the endocrine system in terms of systemic dysfunction. The book is organized in terms of each gland and its ramifications on the various tissues and organs of the body in health and disease. Each gland is evaluated in terms of structure and function in the normal and dysfunction in various illnesses. The views expressed embody thoughts that have stood the tests of time, as well as current concepts that are non-controversial. Clinical aberrations are illustrated with case citations. Each chapter contains a selected bit of world literature from which standard knowledge has been culled. The appendix includes a series of laboratory tests in endocrine function invaluable in everyday practice.

I. NEWTON KUGELMASS

Therapy of Dermatologic Disorders, Including a Guide to Diagnosis and a Dermatologic Pharmacopeia. By Samuel M. Peck, B.S., M.D., Philadelphia, Pa., Lea & Febiger, 1951. 383 pp. $6.50.

This therapeutic outline on everyday problems of dermatology reflects the personal experience of the authors. It thus constitutes a good guide for the beginner in dermatologic therapy. There is, however, an extensive chapter on the dermatologic pharmacopeia for the experienced dermatologist. There is an excellent chapter on differential diagnosis originally evolved by Saboraud. There is an excellent classification of skin disorders in accordance with the National Conference on the nomenclature of disease. Each disease is discussed from the standpoint of etiology and diagnosis with the greatest emphasis on treatment. This compendium is invaluable for effective management of common skin diseases.

I. NEWTON KUGELMASS

The Physiology and Pathology of Hemostasis. By Armand J. Quick, Ph.D., M.D., Philadelphia, Pa., Lea & Febiger, 1951. 188 pp. 18 ills. $4.00.

Tremendous strides have been made in the past decade in the study of the mechanism of blood coagulation. There is great confusion in the radical changes in the basic concepts as well as in the new terminology. The author assembles these new facts and interprets them for clinical application. Viewed from such a standpoint the classification of hemorrhagic diseases becomes more fundamental and the therapy more rational. After an historical development of underlying concepts of hemostasis, the author proceeds to unify the theories into a working basis. This enables a classification based upon deficiency or excess of each of the clotting components. The chapter on venous thrombosis is the outgrowth of cooperation with surgeons.

I. NEWTON KUGELMASS

Pharmacology and Pharmacotherapeutics for Dentists. By William H. O. McGee, D.D.S., M.D., F.A.C.D. and Melvin W. Green B.S., Ph.D., Philadelphia, Pa., The Blakiston Company, 1951. 4th Edition. 550 pp. 14 ills. $7.50.

The fourth edition of this book has taken into consideration all the advances during the past five years. Many parts of the text have been revised and rewritten in the light of these recent advances. The content of the book has been limited chiefly to a description of scientifically proved findings.

By simply checking the index against the text with such headings as antibiotics, antihistamines, flourines, ammoniated dentifrices, mouth washes, peroxide and vitamins one can find invaluable, accurate and up to date answers to these and a host of other dental problems which are uppermost in the mind of the busy practitioner who has little time to wade through a formal textbook on pharmacology.

Except for a few minor suggestions, the book could be considered almost perfect. The authors could have deleted the formulas for Hartman's solution, compound solution of sodium sulfide and acetyl salicylic acid paste compound because of their questionable therapeutic effects. It also, would be well to check the dosages of vitamins on page 524. Another suggestion would be for the authors to substitute the word gingivae for gums which would be more in keeping with the scientific quality of the book.

Without losing any of its factual scientific data these authors, experienced in teaching dentists and dental students, have improved this new edition to such an extent that a most complex subject has been rendered facile and interesting.

Any student teacher or practitioner in the field of dentistry could profitably use this book to save valuable time and effort because here in one compact text the authors have distilled pharmacology and pharmacotherapeutics so that it has practical significance for ministers of all phases of dental health service.

HARRY ROTH

ABSTRACTS

Recent Advances in Nutrition. By Paul R. Cannon, Ph.D., M.D., Lawrence, Kansas, University of Kansas Press, 1950. Price $2.00.

This series of three lectures presented to the students and faculty of the University of Kansas School of Medicine presents the conclusions of detailed experimental work on protein metabolism using the "Rat-Repletion Method." The results of these tests add invaluable information to our limited understanding of the esssential amino acids in protein reserves and in resistance to infection.

The *first lecture* of this series deals with the problem of the essential amino acids, their relationship to dietary protein, and with the relationship of antibody mechanism to the processes of acquired resistance to bacterial infection.

The nutritive value of a protein depends mainly on its essential amino acids. With newer analytical methods, it is possible to recognize specific amino acid deficiencies in food and to recommend appropriate supplementation. The Rat-Repletion Method used by the author and his group offers a rapid and comparatively simple method of measuring protein values under normal circumstances and modified by storage conditions and processing methods. Charts and graphs are presented.

This same method was used to test protein metabolism in relation to acquired resistance to bacterial infection. It was found that protein depleted animals were considerably more susceptible to induced infection and also less immunizable than well nourished ones. It is suggested that increased susceptibility to infection displayed by starving persons may be best attributed to depletion of protein reserves and inability to fabricate new supplies of antibody globulin which contains all of the essential amino acids.

In the *second lecture,* the author discussed the dietary essentials in relation to tissue protein synthesis. He states that, "the process of convalescence is essentially a nutritional problem of tissue synthesis and it includes such varied syntheses as the regeneration of muscle mass, of blood and tissue proteins, of red blood cells, leukocytes, and certain hormones and enzyme systems." Consequently, the problem in treating the debilitated patient is determination of the diet that will best restore him to his original state.

Since the living organism operates to release food energy and to build and maintain tissues from the same materials, it is necessary to think not only in terms of high caloric diet, but of amino acids. The repletion technique gives ample evidence to emphasize the fact that protein utilization requires an adequate caloric intake.

The role of vitamins in relation to tissue protein synthesis was next studied using the Rat-Repletion Method. The lack of riboflavin particularly led to a partial block in the process of protein synthesis. It is inferred that riboflavin deficiency hampers construction of tissue protein as in muscle.

The next study was a quantitative analysis of the essential amino acids in their application to tissue synthesis. It was shown that not only were all essential amino acids necessary, but each was necessary in amounts no less than the minimal daily requirement for the maintenance of appetite and the rebuilding of tissue. The abundance of one did not compensate for the subminimal requirement in another. Further testing included feeding the essential amino acids together or in groups to determine the necessity of simultaneous availability. By establishing two groups of five essential amino acids and by feeding simultaneously, alternately, and at intervals, it was shown that an animal cannot eat one set of rations quickly enough in relation to the other to enable the second group to combine with those of the first to accomplish tissue synthesis. The author feels that these experiments are most challenging in that they indicate the importance of simultaneous availability of the essential amino acids.

The *last lecture* of this series presents the pathologic aspects of protein nutrition and their relationship to amino acid utilization. Severe and prolonged protein deficiency may adversely affect many bodily processes. In the course of disease, whether due to inadequate ingestion of protein, loss of body tissue,, or interference with formation of tissue protein, the results will be a general tissue protein deficiency. Thus, in severe burns, nephrosis, cirrhosis, massive infection with discharge of purulent material, starvation, and malignancy, there will be a depletion in the protein stores. When protein reserve becomes diminished, the enzyme system is affected, resulting in reduced rate of protein metabolism. Further research in man and rats by W. C. Rose indicates that in the course of injury with negative nitrogen balance, specific essential acids may be depleted resulting in a casting off of those acids not utilized. This might indicate specificity of amino acids from a therapeutic standpoint.

MELVIN JON POMERANZ

ANNOUNCEMENTS

Postgraduate Training in Periodontia and Oral Medicine New York University College of Dentistry

The Periodontia Department of New York University College of Dentistry which has been giving postgraduate courses in this subject since 1926, announces its full time course in Periodontia and Oral Medicine for one academic year, September 22nd, 1952 to May 22nd, 1953, leading to a certificate. The course is limited to four. Half-time two year courses are also given as well as a three weeks refresher course beginning June 2nd, 1952. All courses are under the direct supervision of Dr. Samuel Charles Miller.

For information concerning the above or courses in other phases of dentistry write to Secretary, Postgraduate Division, New York University College of Dentistry, 209 East 23rd Street, New York 10, N. Y.

The Third Annual Berkshire Conference in Periodontology and Oral Pathology

The Division of Graduate and Post-Graduate Studies of Tufts College Dental School will conduct the Third Annual Berkshire Conference in Periodontology and Oral Pathology at Eastover, a resort hotel in Lenox, Massachusetts, June 15 to June 19, 1952. The conference will consist of four days of lectures, seminars, and panel discussions regarding clinical problems by outstanding teachers and clinicians in dentistry, medicine, and their related fields.

Included amongst the faculty and subjects to be considered are:

Col. Joseph L. Bernier, D.D.S., M.S. — Chief of the Dental and Oral Pathology Section of the Armed Forces Institute of Pathology; Pathologist to the Registry of Dental and Oral Pathology.

Subject: "Histopathology of Oral Mucous Membrane Lesions Other Than Tumors."

Louis Blatterfein, D.D.S. — Assistant Professor of Denture Prosthesis, New York University College of Dentistry.

Subject: "Partial Denture Prosthesis And The Periodontal Problem."

William Dameshek, M.D. — Professor of Clinical Medicine, Tufts College Medical School, Senior Physician and Hematologist, New England Medical Center.

Subject: "Clinical Hematology."

Irving Glickman, B.S., D.M.D. — Professor of Oral Pathology and Periodontology, Director of the Division of Graduate and Post-Graduate Studies, Tufts College Dental School.

Subject: "Present Day Frontiers In The Periodontal Field."

Herbert H. Kabnick, D.D.S. — Formerly Associate Professor in Charge of Crown and Bridge Department, New York University College of Dentistry.

Subject: "Fixed Bridge Prosthesis and the Periodontal Problem."

Samuel Charles Miller, D.D.S. — Professor and Head of Department of Periodontia, New York University College of Dentistry.

Subject: "Psychosomatics in Periodontal Diagnosis."

Stanley Robbins, M.D. — Associate Professor of Pathology, Boston University School of Medicine, Associate Pathologist, Mallory Institute, Boston City Hospital, Boston, Mass.

Subject: "General Principles of Neoplastic Disease."

Hamilton B. G. Robinson, D.D.S., M.S. — Professor of Oral Pathology and Oral Diagnosis, Ohio State University.

Subject: "Oral Neoplasms."

(*Continued on next page*)

Hans Selye, M.D. — Professor and Director of the Medical Institute of Experimental Surgery, University of Montreal.

Subject: "The General Adaptation Syndrome."

Frederick Stare, M.D. — Professor of Nutrition, Harvard University Medical School.

Subject: "Clinical Nutrition."

John R. Thompson, D.D.S. — Professor and Director of the Department of Orthodontics, Northwestern University, Director of Northwestern University Cleft Palate Institute.

Subject: "Fundamental Principles Governing Orthodontic Periodontal Relationships."

David Weisberger, M.D., D.M.D.—Associate Professor of Dental Medicine, Harvard School of Dental Medicine, Chief of the Dental Department, Massachusetts General Hospital.

Subject: "Clinical Management of Oral Mucous Membrane Lesions Other Than Tumors."

The curriculum is arranged so that the mornings and evenings are devoted to professional activities, with afternoons open for recreation. A special activities program is scheduled for the ladies. Tuition—$100.00. Room, board and incidentals—$70.00 per person. For further information regarding this conference write:

The Berkshire Conference
Tufts College Dental School
136 Harrison Avenue
Boston 11, Massachusetts

District of Columbia Dental Society's 20th Annual Meeting

The District of Columbia Dental Society's 20th Annual Postgraduate Clinic will be held March 9—12, 1952, at the Shoreham Hotel, Washington, D. C.

Each year, this meeting is growing in scientific, social and commercial value, and this forthcoming meeting will prove no exception.

There will be nationally known clinicians and essayists, speakers of wide renown, exhibitors showing the latest and newest products, registered clinics, table clinics, visual education, important scientific sessions, and fine social entertainment.

The registered clinicians, who will present postgraduate courses and their subjects, are: Dr. Harrison M. Berry, Jr., Roentgenology; Dr. John G. Brauer, Children's Dentistry; Dr. G. R. Lundquist, Periodontia; Dr. Andy W. Sears, Crown & Bridge; Dr. Thomas H Forde, Dr. James J. Greeves, Dr. Edward Koltisko, Dr. John. T. McSweeney, Oral Dynamics; Col. Lynn C. Diksen, (DC) U. S. A., and Lt. Col. Paul A. Miller, (DC), U. S. A., Prosthodontia, Lt. Comdr. W. E. Hedman, (DC), U. S. N., Endodontia.

Dr. J. Garrett Reilly, General Chairman of the Postgraduate Clinic, has stated "every effort is being made to give members of the dental profession a well balanced educational and scientific program."

A Message of Sympathy

(*Editor's Note*: News of Dean Wright's death was received just prior to the publication of this issue. Following is a letter sent to Mrs. Wright by our President, Harold K. Gelhaar.)

Dear Mrs. Wright:

With deep regret we learn of the death of your husband Dr. Walter H. Wright.

His prominent position in the field of dentistry was an enviable one. Many years of close association in the profession with organized groups and contact with its members and students will long be remembered.

I well recall his initiation as our first Honorary Member and the joy that was ours in having such a distinguished gentleman as one of our group.

Please accept, in behalf of the membership of the American Academy of Dental Medicine, our deepest sympathy in your great loss which is, in great measure, our loss also.

Most sincerely,

HAROLD R. GELHAAR, *President*

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